UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

Chantix (varenicline)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

Diagnosis_____

All information to be legible, complete and correct or form will be returned

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PRIOR AUTHORIZATION MAY BE OBTAINED WITH A TELEPHONE CALL FROM THE PRESCRIBER OR PHARMACY

CRITERIA:

- Minimum age requirement**:** 18 years old
- To be used for smoking cessation

AUTHORIZATION:

Authorization is granted for 24 weeks per lifetime.

RE-AUTHORIZATION:

None

2/20/07